The Centre for Family Medicine
Family Health Team
Ontario

Ontario
Waterloo Wellington Local
Health Integration Network

WW WHEELCHAIR & SEATING CLINIC

REFERRAL FORM

Name:	Date of Birth:
Health Card Number:	
Street Address:	
City:	Postal Code:
Home Phone Number:	Work/Cell Phone Number:
Alternative Contact: (If necessary)	Relationship:
Home Phone Number:	Work/Cell Phone Number:

Diagnosis/Medical History:

Do you currently use a wheelchair or scooter? ☐ Yes ☐ No

If Yes: What type of device: ☐ walker ☐ manual wheelchair ☐ scooter ☐ power wheelchair ☐ power seating

How old is this device? _____ Seating? _____

Concerns with current device:

☐ condition of current wheelchair/scooter
☐ condition of current seating
☐ wrong size
☐ change in mobility or functional status
☐ posture or position
☐ pain or discomfort
☐ skin breakdown/ pressure
☐ Other: _____

Have you been seen for a wheelchair/seating assessment in the last year? ☐ Yes ☐ No
If Yes – what was the outcome of that assessment and why do you require a re-assessment?

Is a mechanical lift needed for transfer to/from the wheelchair? ☐ Yes ☐ No

Is an attendant needed for care needs during appointments? ☐ Yes ☐ No

Power of Attorney for Personal Care or Substitute Decision Maker (if Applicable) :

Name:_____ Relationship:_____ Phone #:_____

Power of Attorney for Finances (if Applicable) :

Name:_____ Relationship:_____ Phone #:_____

Referral Source: (if other than self).
NOTE: Only self-referrals should be emailed. All other referrals should be made by fax (see information below).

Name:	Relationship:
Phone Number:	Fax:

Referrals will be reviewed and patients will be contacted directly with an appointment time

16 Andrew St. Kitchener, ON N2H 5R2

phone: 519-804-9897 fax: 519-804-1467 email: seating@family-medicine.ca (self-referrals only)